STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	009856	A. BUILDING: _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL-FORT WAYNE	700 BROADWAY 7TH FL E FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one hospital licensure complaint. Complaint Number: IN00141841 Unsubstantiated: Lack of Sufficient Evidence Facility Number: 009856 Date: 2/6/14 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Select Specialty Hospital-Fort Wayne is in compliance with 410 IAC 15-1.5-6, Nursing Services, Indiana Hospital Licensure Rules. QA: claughlin 02/12/14	S 000		